

Item 20b Film 223 12-8-57

11846

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Finchville				d. STREET ADDRESS Near Brookview			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Wyatt Middle Jefferson Last Arnett				4. DATE OF DEATH Month November Day 28 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1924	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.		IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Dupont Company		11. BIRTHPLACE (State or foreign country) New Castle, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. Arnett				14. MOTHER'S MAIDEN NAME Mannie E. Marine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 180-16-6747		17. INFORMANT Address Mrs. Wyatt J. Arnett, Rhodesdale, Md., RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter Cranial injury DUE TO 822x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures skull DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Instant Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which overturned.					
20c. TIME OF INJURY Month, Day, Year 1:10 p.m. 11/28 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 392		20f. (City or town) (County) (State) Finchville, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 5 57		24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 5 1957

RECEIVED

; 11845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD #3		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge RFD # 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret E. Middle Bennett Last Bennett		4. DATE OF DEATH Month Nov Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge RFD # 3		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Rhea		14. MOTHER'S MAIDEN NAME Martha Spedden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George H. Bennett		Address Cambridge RFD # 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Starvation DUE TO Psychosis and Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis (Extensive)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/20 , 19 50 , to 11/3 , 19 57 ; that I last saw the deceased alive on 11/3 , 19 57 , and that death occurred at 6 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Hanks		ADDRESS (Street, city or town, state) 104 Lousier St Cambridge Md	
PHYSICIAN'S NAME (Type) W. H. Hanks		DATE SIGNED 11/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/57	
22c. NAME OF CEMETERY OR CREMATORY Spedden Swards		22d. LOCATION (City, town, or county) (State) Neck Dist. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE 11/4/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Zella</u> Middle <u>Ellen</u> Last <u>Booze</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 /14/1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hoopersville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel T. Hooper</u>				14. MOTHER'S MAIDEN NAME <u>Susan Meekins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Romie C. Booze</u>			Address <u>Hoopersville Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 12, 1957</u> , to <u>Nov. 8, 1957</u> , that I last saw the deceased alive on <u>Nov. 8, 1957</u> , and that death occurred at <u>10 45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Baumann</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u>		DATE SIGNED <u>11-9-57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				24a. REC'D BY REGISTRAR <u>DATE 11/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-2-57 et

CERTIFICATE OF DEATH

11844
 11/6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>			c. LENGTH OF STAY IN 1b <u>2 months</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Clifford</u> Last <u>Bounds</u>			4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Hubert J. Bounds</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Malone</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Eastern Shore State Hospital records</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)			(State)	
21. I certify that I attended the deceased from <u>9-28</u> , 1957, to <u>Nov 22</u> , 1957, that I last saw the deceased alive on <u>Nov 22nd</u> , 1957, and that death occurred at <u>2:00 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/25/57</u>		<u>East New Market</u>		<u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. McElroy, Jr.</u>				ADDRESS <u>C. N. Martin</u>		24a. REC'D BY REGISTRAR <u>John McElroy Jr.</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>Nov 27 1957</u>			

11848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY DORCHESTER Bal.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island			c. LENGTH OF STAY IN 1b 1 Day			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 3 Vol-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor's Island				d. STREET ADDRESS 1212 Steelton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Garfield Buddy Clark				4. DATE OF DEATH Nov. 8 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/17/1926		
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator			10b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Edward Clark				14. MOTHER'S MAIDEN NAME Bertha (unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War 11				16. SOCIAL SECURITY NO. 235-38-4663		17. INFORMANT Mrs. Swannie Belle Clark 1212 Steelton Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 850.x IMMEDIATE CAUSE (a) Accidental Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH Instant							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat capsized.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 10-8- 1957			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay		20f. (City or town) (County) (State) Nr. Taylor's Island Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cemetery		
				22d. LOCATION (City, town, or county) (State) Baltimore Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons				ADDRESS Baltimore 17, Md.		24a. REC'D BY REGISTRAR DATE 11/14/57		
				24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 10/9/57		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11846

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>1 Hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Jones</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/1895</u>
9. AGE (in years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Bishops Head Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred E. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph M. Collins</u>		Address <u>218 Academy St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		DATE SIGNED <u>11/30/57</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24a. REC'D BY REGISTRAR <u>Cambridge Md.</u> DATE <u>11/30/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

RECEIVED

DEC 4 1957

BUREAU V. 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. SIGNATURE OF ATTENDING PHYSICIAN: _____
12. DATE OF DEATH: _____

13. SIGNATURE OF CORONER: _____
14. DATE OF DEATH: _____

15. SIGNATURE OF JURY: _____
16. DATE OF DEATH: _____

17. SIGNATURE OF JURY: _____
18. DATE OF DEATH: _____

19. SIGNATURE OF JURY: _____
20. DATE OF DEATH: _____

21. SIGNATURE OF JURY: _____
22. DATE OF DEATH: _____

23. SIGNATURE OF JURY: _____
24. DATE OF DEATH: _____

25. SIGNATURE OF JURY: _____
26. DATE OF DEATH: _____

27. SIGNATURE OF JURY: _____
28. DATE OF DEATH: _____

29. SIGNATURE OF JURY: _____
30. DATE OF DEATH: _____

31. SIGNATURE OF JURY: _____
32. DATE OF DEATH: _____

33. SIGNATURE OF JURY: _____
34. DATE OF DEATH: _____

35. SIGNATURE OF JURY: _____
36. DATE OF DEATH: _____

37. SIGNATURE OF JURY: _____
38. DATE OF DEATH: _____

39. SIGNATURE OF JURY: _____
40. DATE OF DEATH: _____

41. SIGNATURE OF JURY: _____
42. DATE OF DEATH: _____

43. SIGNATURE OF JURY: _____
44. DATE OF DEATH: _____

45. SIGNATURE OF JURY: _____
46. DATE OF DEATH: _____

47. SIGNATURE OF JURY: _____
48. DATE OF DEATH: _____

49. SIGNATURE OF JURY: _____
50. DATE OF DEATH: _____

51. SIGNATURE OF JURY: _____
52. DATE OF DEATH: _____

53. SIGNATURE OF JURY: _____
54. DATE OF DEATH: _____

55. SIGNATURE OF JURY: _____
56. DATE OF DEATH: _____

57. SIGNATURE OF JURY: _____
58. DATE OF DEATH: _____

59. SIGNATURE OF JURY: _____
60. DATE OF DEATH: _____

61. SIGNATURE OF JURY: _____
62. DATE OF DEATH: _____

63. SIGNATURE OF JURY: _____
64. DATE OF DEATH: _____

65. SIGNATURE OF JURY: _____
66. DATE OF DEATH: _____

67. SIGNATURE OF JURY: _____
68. DATE OF DEATH: _____

69. SIGNATURE OF JURY: _____
70. DATE OF DEATH: _____

71. SIGNATURE OF JURY: _____
72. DATE OF DEATH: _____

73. SIGNATURE OF JURY: _____
74. DATE OF DEATH: _____

75. SIGNATURE OF JURY: _____
76. DATE OF DEATH: _____

77. SIGNATURE OF JURY: _____
78. DATE OF DEATH: _____

79. SIGNATURE OF JURY: _____
80. DATE OF DEATH: _____

81. SIGNATURE OF JURY: _____
82. DATE OF DEATH: _____

83. SIGNATURE OF JURY: _____
84. DATE OF DEATH: _____

85. SIGNATURE OF JURY: _____
86. DATE OF DEATH: _____

87. SIGNATURE OF JURY: _____
88. DATE OF DEATH: _____

89. SIGNATURE OF JURY: _____
90. DATE OF DEATH: _____

91. SIGNATURE OF JURY: _____
92. DATE OF DEATH: _____

93. SIGNATURE OF JURY: _____
94. DATE OF DEATH: _____

95. SIGNATURE OF JURY: _____
96. DATE OF DEATH: _____

97. SIGNATURE OF JURY: _____
98. DATE OF DEATH: _____

99. SIGNATURE OF JURY: _____
100. DATE OF DEATH: _____

CERTIFICATE OF DEATH

Reg. Dist. No. 296

1. PLACE OF DEATH a. COUNTY <u>Eastern Shore State Hosp - MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md -</u> b. COUNTY <u>TA/1601</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXFORD Md - 2000-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp -</u>		d. STREET ADDRESS <u>Stewart Ave -</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles -</u> Middle <u>Henry</u> Last <u>Callison</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>US -</u>		12. CITIZEN OF WHAT COUNTRY? <u>US -</u>	
13. FATHER'S NAME <u>Wm. H. Collison -</u>		14. MOTHER'S MAIDEN NAME <u>Bell -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-7452</u>	
17. INFORMANT <u>Charles C Callison</u> Address <u>Newcastle Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma prostate & Metastasis to Spine</u> 177X DUE TO <u>Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chr. Brain Syndrome & Psychosis</u> (c) <u>Chr. Brain Syndrome & Psychosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia -</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-28</u> , 19 <u>57</u> , to <u>11-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-28</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Noon</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Edwin Howard</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec. 2, 1957</u>	<u>Oxford Cemetery</u>	<u>Oxford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24b. REGISTRAR'S SIGNATURE	
<u>Maurice E. Krummason</u> <u>Easton, Md</u>		<u>71 R. Newell</u>	
24a. REC'D BY REGISTRAR		DATE <u>12/2/57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madison, Md. x0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		d. STREET ADDRESS <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Preston</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/17</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Marvin Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Keene</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Police Dept. Cambridge, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercranial injury</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shot gun wound of head.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot gun wound of head.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> <u>a.m.</u> <u>Nov. 16</u> <u>1957</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parked car.</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Madison Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Clair</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>11/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten information.

RECEIVED
NOV 25 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE			c. LENGTH OF STAY IN 1b 30 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First GILBERT Middle COTTMAN Last COTTMAN				4. DATE OF DEATH Month II Day I Year 1957			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months 6 Days 2		IF UNDER 24 HRS. Hours 1 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY FACTORY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ROUTH COTTMAN				14. MOTHER'S MAIDEN NAME MOLLIE DEVINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-38-8533		17. INFORMANT Address ALBERT COTTMAN PRINCESS ANNE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA. 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 490x DUE TO (c) 490x						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x T.B.C. + SYPHILIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 OCT, 1957 to 1 NOV, 1957 that I last saw the deceased alive on 1 NOV, 1957 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter E. Gunby Jr.				ADDRESS (Street, city or town, state) 105 CHURCH		DATE SIGNED 4 NOV	
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. CAMBRIDGE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/10/57		22c. NAME OF CEMETERY OR CREMATORY ST MARKS		22d. LOCATION (City, town, or county) (State) OAKVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr. Princess Anne, Md.				24a. REC'D BY REGISTRAR DATE NOV 12 1957		24b. REGISTRAR'S SIGNATURE John Thomas Jr.	

CERTIFICATE OF DEATH

PLACE OF DEATH A. HOME		B. HOSPITAL		C. OTHER	
1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. OTHER	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF OTHER	
16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11850

CERTIFICATE OF DEATH

11849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>2040.2</u>			
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Council</u> Last <u>L</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 27 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>		IF UNDER 24 HRS. Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>James Smith</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Eastern Shore State Hospital records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> 450.0 DUE TO <u>Link</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Link</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 28, 1956</u> , to <u>Nov 10, 1957</u> , that I last saw the deceased alive on <u>Nov 10, 1957</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u>				ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>Nov 10 '57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 13, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Masey</u>				24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Masey</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

NOV 13 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 11834 CERTIFICATE OF DEATH

11850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>114 Glasgow St.</u>				d. STREET ADDRESS <u>114 Glasgow St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Hallie</u> Last <u>Creighton</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/16/1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Hoopers Island Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert T. Creighton</u>				14. MOTHER'S MAIDEN NAME <u>Addie Meekins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-12-6732</u>		17. INFORMANT <u>Hallie Creighton</u> Address <u>Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Hypertensive Cardiac</u> DUE TO <u>with atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deceased had been clean</u> DUE TO <u>5 yrs.</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> (Not while of work) <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 24, 1957</u> , to <u>Nov 25, 1957</u> , that I last saw the deceased alive on <u>Nov. 24, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the cause, and on the date stated above. ADDRESS (Street, city or town, state) <u>144 Rte 1 Cambridge Md</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>John E. Meekins</u> M.D. PHYSICIAN'S NAME (Type) <u>GILBERT E. MEEKINS</u> <u>Cambridge Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Cambridge Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Meekins</u>	

BUREAU V. S.

DEC 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenburn Convelesent Home</u>			d. STREET ADDRESS <u>Cmabridge Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sallie</u> Middle <u>Wilson</u> Last <u>Dail</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>24,</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1866</u>	9. AGE (in years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge RFD # 3</u>	
13. FATHER'S NAME <u>Levin Dail</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah E. Wilson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Wilson Dail</u> Address <u>Cambridge Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/29/57</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cambridge Md.</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1853

RECEIVED
DEC 4 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. STREET ADDRESS <u>11 Fairmount Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Luveina</u> Middle <u>Dashfield</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown 1884</u>
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Train Bechum Weatherley</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Young</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-14-7606</u>		17. INFORMANT <u>Daniel Weatherley- brother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial injury</u> <u>812x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple fractures of skull.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was struck by a car while walking on road.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:50</u> <u>11/28</u> <u>57</u> Hour <u> </u> Minute <u> </u> P. M. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Glasgow St.</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Aireys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aireys Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>12/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

SIGNATURE OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

SIGNATURE OF SIGNER

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11851

CERTIFICATE OF DEATH

11852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 mo. 7 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Route #2.	
3. NAME OF DECEASED (Type or print) First Estelle Middle Lee Last Dennis		4. DATE OF DEATH Month November Day 12 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-04
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Parsons (James M. Parsons)		14. MOTHER'S MAIDEN NAME Ernie (Olevia Ernie Perdue)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Encephalitis 309X DUE TO Chronic Brain Syndrome With Psychosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5 , 19 57 , to November 12 , 19 57 , that I last saw the deceased alive on November 12 , 19 57 , and that death occurred at 4:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edwin J. Ward M.D. E.S.S. Hospital, Cambridge, Md. November 12 1957 PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15. 57.	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Walston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		24. REC'D BY REGISTRAR Salisbury, Maryland.	
24b. REGISTRAR'S SIGNATURE John Mose Jr.		DATE 11/14/57	

NOV 25 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11852

Item 2 Film G223 11-29-57 et

CERTIFICATE OF DEATH

11853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary Md.</u>				c. LENGTH OF STAY IN 1b <u>Several Yr.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>/Secretary/Md. x 2 Madison</u>				d. STREET ADDRESS <u>Secretary/Md. /</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mattie Merrick's Con. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Mae</u> Last <u>Fitzhugh</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>19 57</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1968</u>		9. AGE (In years last birthday) yrs. <u>89</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Miles Earhart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Alberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Dolle Baltimore Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332x</u> IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>57</u> , to <u>10 NOV</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 NOV.</u> , 19 <u>57</u> , and that death occurred at <u>9:25 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u>		ADDRESS (Street, city or town, state) <u>105 CHURCH ST. CAMBRIDGE MD.</u>					
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR</u>		DATE SIGNED <u>CAMBRIDGE MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Joppa Church</u>		22d. LOCATION (City, town, or county) (State) <u>Madison Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/15/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John D. Hare Jr.</u>			

CERTIFICATE OF DEATH

1957

FILE NO.

NAME		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER		REMARKS		REMARKS	
RELIGION		METHODIST		ROMAN CATHOLIC		UNITED METHODIST		UNITED BRETHREN		UNITED PRESBYTERIAN		UNITED LUTHERAN		OTHER	
RACE		WHITE		BLACK		HISPANIC		ASIAN		OTHER		REMARKS		REMARKS	
CAUSE OF DEATH		HEART		LUNGS		LIVER		KIDNEYS		STOMACH		INTESTINES		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		REMARKS		REMARKS	
DATE OF DEATH		1957		1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		PRISON		OTHER		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

104000

CERTIFICATE OF DEATH

NAME		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER		REMARKS		REMARKS	
RELIGION		METHODIST		ROMAN CATHOLIC		UNITED METHODIST		UNITED BRETHREN		UNITED PRESBYTERIAN		UNITED LUTHERAN		OTHER	
RACE		WHITE		BLACK		HISPANIC		ASIAN		OTHER		REMARKS		REMARKS	
CAUSE OF DEATH		HEART		LUNGS		LIVER		KIDNEYS		STOMACH		INTESTINES		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		REMARKS		REMARKS	
DATE OF DEATH		1957		1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		PRISON		OTHER		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

BUREAU V. 2

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md. b. COUNTY Dor.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.S.H.				d. STREET ADDRESS Cambridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Frank Middle Fountain Last Fountain				4. DATE OF DEATH Month Nov. Day 10 Year 1957				
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/86		
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 15 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fountain				14. MOTHER'S MAIDEN NAME Wilhemina Mills				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-14-1465		17. INFORMANT Records E.S.S. Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/12/57		22c. NAME OF CEMETERY OR CREMATORY Dor-Mem-Park		
22d. LOCATION (City, town, or county) Cambridge, Md.				22e. (State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 11/13/57		
24b. REGISTRAR'S SIGNATURE 								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

NOV 25 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11837

CERTIFICATE OF DEATH

11855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN IB <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				d. STREET ADDRESS <u>214 Sheppard Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>Gould</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Rhodesdale Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Gould</u>				14. MOTHER'S MAIDEN NAME <u>Hester Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Edith Gould</u> Address <u>Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchogenic carcinoma, Rt. Lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis, generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>3 -6 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4th</u> , 19 <u>57</u> , to <u>Nov. 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>57</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust street</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u> <u>Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/29/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mearns</u>			

MEDICAL CERTIFICATION

2

67

1

0

VS AIS (4)
ISM 9/55

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11856

11838

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 Washington St.</u>				d. STREET ADDRESS <u>303 Washington St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Twilley</u> Last <u>Latta</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. A. Twilley</u>				14. MOTHER'S MAIDEN NAME <u>Sophia E. Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Doris G. Cook Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/28/57</u> , 19 <u>57</u> , to <u>11/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>57</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge Md.</u>			
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				DATE SIGNED <u>11/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John MacIsaac</u>			

CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. PLACE OF DEATH [Faint text]		6. TIME OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF DECEASED [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF DECEASED [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF DECEASED [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]		33. SIGNATURE OF DECEASED [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]		39. SIGNATURE OF DECEASED [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]		45. SIGNATURE OF DECEASED [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]		51. SIGNATURE OF DECEASED [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF DECEASED [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]		63. SIGNATURE OF DECEASED [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]		69. SIGNATURE OF DECEASED [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]		75. SIGNATURE OF DECEASED [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]		81. SIGNATURE OF DECEASED [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF DECEASED [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]		93. SIGNATURE OF DECEASED [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]		99. SIGNATURE OF DECEASED [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF DECEASED [Faint text]		102. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 2

DEC 4 1957

RECEIVED

11839

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5, See: Birth Cert. et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Chesapeake Court</u>				d. STREET ADDRESS <u>19 Chesapeake Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Darlene</u> Middle <u>Midgett</u> Last <u>Midgett</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 9, 1957</u>		9. AGE (In years last birthday) yrs. <u>8</u> Months <u>10</u> Days <u>10</u> Hours <u>Min.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Midgett</u>				14. MOTHER'S MAIDEN NAME <u>Avondorine Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital malformation of heart</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>754.4</u> (a), stating the underlying cause lost, DUE TO (c) <u>754.4</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Clair</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/20/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2067214XV5

11858/

Reg. Dist. No. _____

11854

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Easton Tilghman 20x22	
3. NAME OF DECEASED (Type or print) First Middle Last Laura BELLE Miller		4. DATE OF DEATH Month Day Year 11 23 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-77
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Dawson Ball		14. MOTHER'S MAIDEN NAME EVA HUNT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Eastern Shore State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Hypertension & Nephritis DUE TO Less Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Bronchopneumonia			
19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-23 , 19 57 , to 11-23 , 19 57 , that I last saw the deceased alive on 11-23 , 19 57 , and that death occurred at 4:55 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edwin F. Wood M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-57	
22c. NAME OF CEMETERY OR CREMATORY Tilghman M.E.		22d. LOCATION (City, town, or county) (State) Tilghman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE P. J. Moore		24a. REC'D BY REGISTRAR NOV 26 1957	
24b. REGISTRAR'S SIGNATURE Dr. John Mac...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

11840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head Md. x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Bishops Head Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Bloodsworth Last Moore		4. DATE OF DEATH Month Nov. Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/1879
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bloodsworth Is. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew H. Bloodsworth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Otis A. Moore		Address Harrington Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO > (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALIGNANCY. Colon (Proven by XRAYs Studies)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24 , 19 57 , to 11/25 , 19 57 , that I last saw the deceased alive on 11/25 , 19 57 , and that death occurred at 12:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Hanks M.D.		ADDRESS (Street, city or town, state) 104 Locust DATE SIGNED 11/25/57	
PHYSICIAN'S NAME (Type) W. H. HANKS MD		CAMBRIDGE, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/57	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE 11/29/57		24b. REGISTRAR'S SIGNATURE John M. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island		c. LENGTH OF STAY IN 1b 2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 0354.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylors Island			d. STREET ADDRESS 964 Renfrew St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Delbert Middle A. Munshower Last			4. DATE OF DEATH Month November Day 8 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/26	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Walter Munshower			14. MOTHER'S MAIDEN NAME Ella Ridinger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wife Address 964 Renfrew St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac cidental Drow ning 850.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Skiff capsized.			
20c. TIME OF INJURY Month, Day, Year 10 a. m. 11-8- 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay	
20f. (City or town) Taylors Island Dor.		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cemetery	
22d. LOCATION (City, town, or county) Baltimore		22e. (State) Md.		22f. REC'D BY REGISTRAR 11/13/57	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Bradley		ADDRESS Baltimore Md.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

RECEIVED

11856

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Parks, Jr.		4. DATE OF DEATH Month November Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-78
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John William Parks		14. MOTHER'S MAIDEN NAME Sarah Whitelock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn.		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 443x DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. DUE TO Hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome With Psychosis			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 19 57 , to November 11, 19 57 , that I last saw the deceased alive on November 11, 19 57 , and that death occurred at 4:06 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin J. Ward		ADDRESS (Street, city or town, state) DATE SIGNED 11-12-57	
PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward		M.D. E.S.S. Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/57	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) not known Md
23. FUNERAL DIRECTOR'S SIGNATURE James Henson		24. REGISTRAR'S SIGNATURE John Macey Jr	
ADDRESS Princess Anne Md		DATE NOV 14 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11841

CERTIFICATE OF DEATH

11862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cross Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Veatrice Parrington</u>				4. DATE OF DEATH Month Day Year <u>Nov. 26, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. AGE (In years last birthday) <u>64</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
13. FATHER'S NAME <u>Charles W. Keene</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Camper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT Address <u>Mrs. Flossie Stanley, Cambridge, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic CVD.</u> DUE TO (c) <u>Arterio-sclerotic CVD.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 1957, to <u>Nov 26</u> , 1957, that I last saw the deceased alive on <u>Nov 25</u> , 1957, and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Cambridge, Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>Nov 30, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Cambridge, Md.</u>			
24a. REC'D BY REGISTRAR <u>[Signature]</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>12/3/57</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		PERMANENT CAUSE		PERMANENT CAUSE		PERMANENT CAUSE		PERMANENT CAUSE	
MEMBER OF THE ARMY		HIGH SCHOOL		MARRIED		METHODIST		SHOOTING		SUICIDE		SHOOTING		SHOOTING		SHOOTING		SHOOTING		SHOOTING		SHOOTING	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		MEMBER OF THE ARMY		MEMBER OF THE ARMY		MEMPHIS		MEMPHIS		1922		1922		MEMPHIS		MEMPHIS		1922		1922	

BURKAY V. B.

DEC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11863

11842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>A.</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 57</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Dunnock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Margaret Hooper</u>		Address <u>Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>11/14/57</u> , 19 <u>57</u> , to <u>11/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hanks</u>		DATE SIGNED <u>11/29/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hanks MD</u>		<u>CAMBRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Muehr</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11843

CERTIFICATE OF DEATH

11864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Willis St.</u>				d. STREET ADDRESS <u>124 Willis St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marcus H. Rhodes</u>				4. DATE OF DEATH Month Day Year <u>Nov. 2, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Brookview Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Callison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Marcus Rhodes 124 Willis St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY THROMBOSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA - UNRESOLVED PNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>57</u> , to <u>11/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>57</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust Cambridge Md.</u> DATE SIGNED <u>11/3/57</u> ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D. <u>W. H. Hanks</u> PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u> <u>CAMBRIDGE Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>LeCompte Funeral Service Cambridge Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11865

11857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rhodesdale - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Finchville				d. STREET ADDRESS Finchville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle R. Last Sheppard				4. DATE OF DEATH Month November Day 5 Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1882		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Evans				14. MOTHER'S MAIDEN NAME Jane Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Elwood Sheppard, Rhodesdale, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. (c) 							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11/7/57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 11/13/57		24b. REGISTRAR'S SIGNATURE W. H. ...	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

11858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg Md.</u>		c. LENGTH OF STAY IN Yr <u>53 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg Md. x 2</u> ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home-Williamsburg Md.</u>			d. STREET ADDRESS <u>Williamsburg Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elizabeth H. Smith</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Madison Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John E. Harrington</u>			14. MOTHER'S MAIDEN NAME <u>Annie E. Harrington</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harrington Smith Williamsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck of Femur on Nov. 3, 1957</u>					
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Nov. 3 19 57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Williamsburg, Dor. Md.</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		DATE SIGNED <u>11/23/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madison Church Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Madison Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge Md.</u>			24a. REC'D BY REGISTRAR DATE <u>11/23/57</u>		
24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

RECEIVED
NOV 29 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11844 CERTIFICATE OF DEATH

11867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. LENGTH OF STAY IN 1b 2 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.				d. STREET ADDRESS 1 Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home Cambridge Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle M. Last Spedden				4. DATE OF DEATH Month Nov. Day 15 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/11/1976	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 15 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Castle Haven Dorchester Col				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William M. Mitchell				14. MOTHER'S MAIDEN NAME Mary Emily Spedden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Sidney Spedden Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA (LOBAR) DUE TO 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 12 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) GENERAL ARTERIO SCLEROSIS - OLD RIGHT HEMIPLEGIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6/27 , 19 57 , to 11/15 , 19 57 , that I last saw the deceased alive on 11/15 , 19 57 , and that death occurred at 12:20 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 105 CHURCH ST. CAMBRIDGE MD			
ACTUAL SIGNATURE Walter E. Gunby Jr				DATE SIGNED 18 NOV 57			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR CAMBRIDGE MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 11/20/57	
				24b. REGISTRAR'S SIGNATURE John Mace Jr.			

